Testimony

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Good morning. My name is Kay Redfield Jamison and I am a professor of psychiatry at the Johns Hopkins School of Medicine and co–director of the Johns Hopkins Mood Disorders Center. I received my Ph.D. from the University of California, Los Angeles in clinical psychology, with a specialization in psychopharmacology. My clinical research interests lie in the study and treatment of mood disorders — depression and bipolar disorder—and in the study and prevention of suicide. I have also studied creativity and literature and have an appointment as Honorary Professor of English at the University of St. Andrews in Scotland. I am here today to speak about my own experiences with manic–depressive illness, also called bipolar disorder, and to strongly advocate for increased research funding for psychiatric illnesses. Before turning to my own experiences, I would like to give a very brief overview of what we know about bipolar disorder.

Manic–depression, or bipolar disorder, is a painful, common, and potentially lethal disorder of mood, thinking, energy, and sleep. It ranges tremendously in severity, from relatively mild expressions to extremely severe, life–threatening and psychotic forms of the illness. The depressive phase — like depression itself — is characterized by a profound lack of energy, apathy, hopelessness, sleeping far too much or far too little, difficulties in thinking, and a loss of pleasure in life. Suicidal and morbid thoughts, as well as undue guilt, are common.

The manic phase is characterized by symptoms in many ways the opposite of those seen in depression. Mood is elevated and expansive, or paranoid and irritable; activity and energy levels are greatly increased; the need for sleep is decreased; speech is fast and excitable, and thinking is very rapid. Other common features of mania are spending large amounts of money, impulsive involvement in questionable endeavors, impatience, and volatility. In its extreme forms mania is characterized by violent agitation, bizarre behavior, delusional thinking, and hallucinations.

What, briefly, do we know about the causes, correlates, and treatment of bipolar illness? First, we know it is genetic. It runs in families. The scientific evidence that bipolar disorder is biological is indisputable. We also know also that the illness is potentially lethal. The mortality rate is very

high. The suicide rate in untreated, severe bipolar illness is 10–15%; 25–50% of people with the disorder will attempt suicide at least once. It has been estimated that at least 70% of the adolescents who commit suicide suffered from a potentially treatable, major mood disorder.

Bipolar illness, like virtually all of the major psychiatric disorders, is an illness of youth; that is, the illness most frequently first occurs in late adolescence or the early twenties. The average age of onset is about 18 years. Men and women are equally liable to bipolar disorder, and alcohol and drug abuse are common. The illness is recurrent and, if not treated, is often progressive; that is, it will tend to worsen over time. About one percent of the population will develop the more severe form of bipolar illness; perhaps two to three percent will have milder forms.

Finally, and most important, bipolar illness is treatable. Most patients will respond to lithium, anticonvulsants, or a combination of anticonvulsants, lithium, and antipsychotic medications. Unfortunately, and unfairly, many people do not have access to good medical care, nor can they afford to pay for the medications that have been prescribed for them.

Although we know much more about this illness than we did even five years ago — thanks in significant measure to the excellent research efforts of the National Institute of Mental Health—there is far too much we do not

know. Only an aggressive and concerted effort to study the underlying causes of bipolar illness will result in earlier and more accurate diagnosis and better, less problematic treatments.

I would like to speak now at a more personal level. Like most people, I had no reason to expect that I would become so seriously, so terribly mentally ill. I certainly had no preparation for insanity. I came from a military and traditional family and, although I had a very extensive family history of bipolar illness, no one talked about it. I had a healthy, active, and very happy childhood and adolescence. I loved school and did well at it, loved sports, was a school leader, and captain of all of my teams.

Then, in my senior year of high school, after a period of much enthusiasm and not much sleep, I became deeply depressed, suicidal, and psychotic. I had never thought of suicide before; now I thought of little else. For much of each day during several months of my senior year in high school, I thought about when, whether, where, and how to kill myself. I learned to present to others a face at variance with my mind; ferreted out the location of two or three nearby tall buildings with unprotected stairwells; discovered the fastest flows of morning traffic; and learned how to load my father's gun.

The rest of my life at the time — sports, classes, writing, friends, planning for college — fell fast into a black night. Everything seemed a ridiculous charade to endure; a hollow existence to fake one's way through as best one could. But, gradually, layer by layer, the depression lifted, and, by the time my senior prom and graduation came around, I had been well for months. Suicide had withdrawn to the back squares of the board and become, once again, simply unthinkable.

Over the years, my manic–depressive illness became much, much worse, and the reality of dying young from suicide became a dangerous undertow in my dealings with life. Then, when I was twenty–eight years old, after a particularly damaging and psychotic mania, followed, in turn, by a particularly prolonged and violent siege of depression, I took a massive, and what I knew to be a lethal overdose of lithium. I unambivalently wanted to die, and nearly did. Death from suicide had become a possibility, if not probability, in my life.

Yet I have been fortunate. My illness responds very well to lithium and I have been well for more than twenty years. I have had the best medical care available and I have been able to afford to pay for it. My family,

friends and colleagues have been surpassingly supportive; most people are not so lucky.

I would like to end with a few beliefs and concerns. As a clinician, I believe there are treatments that can save lives; as one surrounded by scientists whose explorations of the brain are elegant and profound, I believe that our basic understanding of the brain's biology is radically changing how we think about both mental illness and suicide; and, as a teacher of young doctors and graduate students, I feel the future holds out great promise for the intelligent and compassionate care of the seriously mentally ill.

Still, the effort to develop new treatments for severe mental illness and to prevent suicide seems remarkably unhurried. Every seventeen minutes in America, someone commits suicide. Where is the public concern and outrage? I have become more impatient in recent years, and am more acutely aware of the problems that stand in the way of denting the death count. I cannot rid my mind of the desolation, confusion, and guilt I have seen in the parents, children, friends, and colleagues of those who kill themselves. Nor can I shut out the images of the autopsy photographs of twelve–year–old children, or the prom photographs of adolescents who within a year's time will put a pistol in their mouths or jump from the top floor of a university dormitory building. Looking at suicide — the sheer

numbers, the pain leading up to it, and the suffering left behind — is harrowing. For every moment of celebration for the science, or in the success of governments, there is a matching and terrible reality of the deaths themselves: the young deaths, the violent deaths, the unnecessary deaths.

Like many of my colleagues who study mental illness and suicide, I have seen time and again the limitations of our science, been privileged to see how good some doctors are, and dismayed by the incompetence of others. Mostly, I have been impressed by how little value our society puts upon saving the lives of those who are in such despair as to want to end them. It is a societal illusion that suicide is rare. It is not. Certainly the mental illnesses most closely tied to suicide are not rare. They are common conditions, and, unlike cancer and heart disease, they disproportionately affect and kill the young.

The tens of millions of Americans who suffer from mental illness deserve compassion and good science. The diseases from which they suffer deserve to be given the kind of research funding commensurate with the pain and death they cause. In short, they deserve action.

Attachment: Biographical sketch